



10 January 2018

Lakes District Health Board  
Corner Arawa and Ranolf Streets (Pukeroa Street)  
Private Bag 3023, Rotorua Mail Centre  
Rotorua 3046, New Zealand  
Telephone 07 348 1199  
www.lakesdhb.govt.nz

Health Sector Workers Network  
E mail: [fyi-request-7002-9ae748de@requests.fyi.org.nz](mailto:fyi-request-7002-9ae748de@requests.fyi.org.nz)

Dear Health Sector Network

**Subject: Official Information Act request Re:restraint**

Thank you for your request for information under the Official Information Act received by Lakes DHB on 13 December 2018. You have asked:

1. *Can you please provide all policy documents relating to restraint practices at Lakes DHB?*

Lakes DHB currently uses the DATIX system to record and register all incidents of restraint. Please find attached the current Restraint policy. It is important to note that the policy is being reviewed as part of the updating process, the new version is not finalised as yet as it has required extensive modification.

Attached is also the new restraint recorded that has be implemented as part of the revised policy.

2. *Are there instances in the last year (June 2016 to June 2017) of the use of mechanical restraints? (i.e. strapping arms to bed) this is also referred to as physical restraint.*

For the July 2013 to June 2017 period there was one patient recorded.

3. *Can you please provide this data for both physical and mental health services and identify the service associated with this data?*

As above there was one recorded for personal health services. This related to a patient transferred from another DHB with the restraint in place, this was discontinued on arrival at Lakes DHB.No events were recorded for mental health services.

4. *This data should be recorded in a Restraint Register and specify the type of restraint used (ie wrist strap) and the start and finish times of each individual mechanical/physical restraint. Obviously the presentation of this data should be anonymised for the protection of privacy*

The only event recorded was for a patient who transferred from another DHB with a restraint in place; this was removed on admission to Lakes DHB.

Yours sincerely

Ron Dunham  
Chief Executive

Cc: sectoroias@moh.govt.nz



**Document No:** 62131

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**TITLE: Restraint Minimisation and Safe Practice Policy and Procedure**

Lakes District Health Board (LDHB) is committed to adherence with the Health and Disability Services (Restraint Minimisation and Safe Practice (RMSP) Standards NZS 8134.2:2008.

The use of restraint is a decision that requires clinical rationale and is not a treatment. It can only be used in the context of best clinical practice. The use of restraints must be minimised or avoided to ensure our progress towards a restraint free environment.

Restraint is only to be used as a last resort when all other interventions have proven unsuccessful and following appropriate assessment. It is only permitted to enhance or maintain the safety of patients.

**1. Statement/Purpose**

To determine LDHB responsibilities and overarching processes in relation to our commitment to the minimisation of restraint in any form.

**2. Scope**

This policy applies to the restraint practices within LDHB hospital and specialist services. This policy applies to all situations where restraint is clinically indicated and justified, where the person requiring restraint is a patient, outpatient, person seeking treatment, or there are reasonable grounds for believing the person is mentally unwell. This policy does not apply to non-clinical situations requiring restraint, for instance involving family/whanau members or visitors. In this context Lakes Security Policy (EDMS 495605) will apply.

**3. Philosophy**

Restraint is a serious clinical intervention and is only to be used as a last resort to protect patients, family/whanau, staff and/or visitors and LDHB property from harm.

**4. Enabler definitions**

**Enablers** are equipment, devices or furniture voluntarily used by a patient/client following appropriate assessment, that limits normal freedom of movement with the intent of promoting independence, comfort and /or safety, e.g. where a patient/client uses bed rails to assist with their mobility in bed (independence) to aid in the positioning of pillows (comfort) or to prevent them falling from the bed (safety).

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There are four sub categories of these;

- Mobility enablers including walking frames, crutches and wheelchairs
- Comfort enablers including reclining chairs, pillows and cushions
- Personal care enablers including tables, utensils, commodes
- Safety enablers including straps, harnesses, wedges, bed rails.

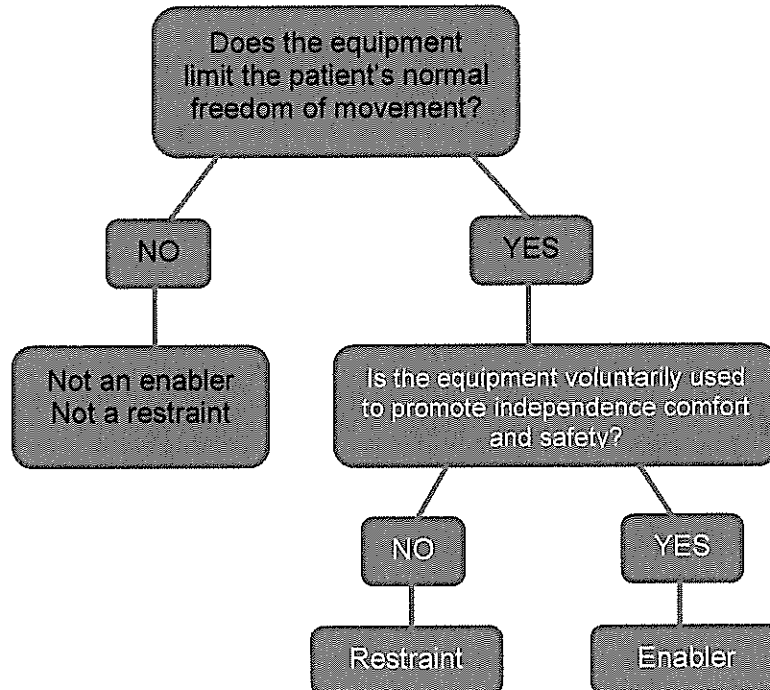
*NB: Deliberate removal of mobility aids is environmental restraint*

**Definition of Equipment / Devices / Furniture**

- Equipment – includes items like wheelchairs, frames, crutches.
- Devices - are items created for a specific purpose including modified utensils.
- Furniture – are items such as reclining chairs and portable tables.

Important – Both enablers and restraint limit a patient's normal freedom of movement. It is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention and whether it is voluntarily used by the patient/client.

Regardless of the intent, an enabler can become a restraint if it is not removed when the patient requests i.e. the enabler ceases to be voluntarily used. See flow chart below.



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**5. Consent to use of enablers**

The intended use of enablers must be explained to the patient, or where applicable, the Enduring Power of Attorney, Welfare Guardian, or in the case of a child under 18 years who is not competent to consent, their parent/guardian, by the appropriate health professional. As a general rule, written consent should be obtained for their use and documented in the clinical notes. See Lakes DHB Informed Consent Policy No 39082.

**6. Restraint definitions**

**Restraint** is the use of any intervention by a service provider without the consumer's informed consent, or where applicable, the informed consent of their Enduring Power of Attorney, Welfare Guardian, or parent/guardian of a child under 18 years, that limits the consumer's normal right to freedom of movement.

All enablers become restraint if used without the patient's consent (or where applicable the consent of their Enduring Power of Attorney, Welfare Guardian, or parent/guardian).

Restraints can be personal, physical or environmental.

- Personal – includes planned personal restraint such as therapeutic holding to assist with IV cannulation or plaster application.
  - Physical – this includes mittens, arm splints, overbandaging
  - Environmental – this includes locking doors, fences and furniture and seclusion (MH only).
- **Personal restraint:**  
**Where a service provider uses their own body to intentionally limit the movement of a consumer.** For example, where a consumer is held by a service provider.
  - **Physical restraint.**  
**Where a service provider uses equipment, devices or furniture that limits the consumer's normal freedom of movement.** For example: where a consumer is unable to independently get out of a chair due to – the design of the chair, the use of a safety belt, or the position of a table or fixed tray.
  - **Environmental.**  
**Where a service provider intentionally restricts a consumer's normal access to their environment.** For example: where a consumer's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as a wheelchair) denied.
  - **Seclusion (Mental Health Specific)**  
**Where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.**

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**Exclusions** – the following do not require consent of the patient or where applicable the Enduring Power of Attorney, Welfare Guardian or parent/guardian of a child under 18 years, as they form the normal care pathway and do not require reporting on the monthly restraint register. However, they must be recorded in the patient's clinical notes.

**Enablers**

- Bedrails in the raised position for patients/clients who are;
  - Unconscious
  - Recovering from anaesthesia
  - In transit
  - On a narrow trolley
  - In ICU/CCU (bedrails permanently attached with built in remotes)
  - Cuddly blanket chest wrap applied to mothers and babies in transit.
  
- In Paediatric Unit – the following are appropriate devices used for safety
  - Cotsides in beds
  - Cots/incubators
  - Highchairs with safety harness
  - Push chairs with 5 point safety harness and brakes
  - Baby chairs with 5 point safety harness and brakes
  - Wheelchairs with lap belts (from factory) or 5 point harness.
  
- Environmental isolation of patients/clients for infection prevention and control purposes.
  
- The restraint of patients/clients who are prisoners for security purposes. The police/prison officer has full responsibility for safe law enforcement restraint practices.
  
- Domestic security – the practice of locking external doors at night for general security.
  
- Night safety orders – used to describe the practice of locking the entry to a patients/clients bedroom overnight at the request of the patient/client.
  
- Therapeutic holding / technical positioning e.g. wedges in theatre to position unconscious patient.

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**7. Patients with learning disabilities/ cognitive/communication difficulties**

These patients may present as confused or become aggressive in response to new situations or experiences they are not familiar with. This may be complicated further if the patient has communication difficulties. A sensitive assessment may identify situations where the patient may respond adversely during their episode of care. Reasonable adjustments may be necessary to ensure patients receive the care and treatment for their needs. It is therefore expected that staff will involve family and/or carers in care planning and preparation of de-escalation techniques prior to delivery of health treatment.

Where a patient lacks the capacity to make an informed decision regarding a planned intervention, consent should be sought from the patient's Enduring Power of Attorney, welfare Guardian, parent/guardian if a child is under 18 years, or if such a person is not available, the views of suitable persons interested in the patient's welfare should be ascertained and taken into account under Right 7(4) of the Code of Health and Disability Service Consumers' Rights.

**8. Managing the risk of violence**

Violence is taken to mean:

- Verbal abuse or threats
- Intimidation
- Physical violence
- Possession of weapons
- Possession of and/or alcohol intoxication
- Possession of and/or recreational drug use

Lakes DHB staff need to be aware that violent situations can escalate quickly and an understanding of warning signs is the first step in de-escalating these situations.

Warning signs;

- Rapid, loud, profuse speech
- Sudden change in demeanour
- Disorientation and/or confusion
- Clenched fists, gritted teeth, reddened face, flared nostrils and rapid breathing
- Increased pacing and/or inability to remain still
- Use of alcohol or drugs
- Threatening behaviours.

**9. Managing challenging behaviours**

Definition:

Challenging behaviour is taken to mean abnormal/unusual behaviours of such an intensity, frequency or duration that the physical safety of the patient/others is likely to be placed in serious jeopardy.

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Every patient identified as having challenging behaviour is to be individually assessed to develop a management plan for their behaviour while on Lakes DHB grounds.

Consultation with the patient or if applicable their Enduring Power of Attorney, Welfare Guardian, parent/guardian if a child is under 18 years, or if such a person is not available, other such suitable persons interested in the patient's welfare is a key requirement in the process. Such a discussion should be recorded in the patient's clinical notes.

The management plan must include;

- A description of the problem behaviour
- Assessment of the potential or possible underlying cause of the behaviour
- Any recurrence patterns
- Planned interventions.

#### 10. De-escalating potential violent situations

If staff members find themselves in a potentially violent situation they should undertake the following (as soon as they are safely able to do so).

Fully employ all known de-escalation skills;

**DO** Ensure there is an escape route and do not let the other person between themselves and the escape route.

**DO** Maintain a safe distance (minimum of 2 metres) and stand side on to the person

**DO** Remove any furniture/equipment that could harm the patient/staff/others

**DO** Remain calm and respond to the other person in a normal tone.

**DO** exit the situation at first sign of violence

**DO** Call 777 for security assistance, identify location and determine if police response is required. MH CATT should be called where/when urgent MH assessment is required.

**DO** Attempt diversion e.g. offer food/drink

**DO** document any violent acts observed or experienced in the patient's clinical notes. Where necessary appropriate debriefing and support needs to be made available to affected staff members.

**DO NOT** turn your back on the other person

**DO NOT** argue with or confront the person

**DO NOT** at any point engage in attempts to physically restrain the person except as an absolute last resort.

**DO NOT** make sudden movements

De-escalation techniques/interventions need to be documented in the patient's clinical notes. By documenting these allows for assessment of the situation and amendment to the patient management plan.

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**11. Recommended restraint assessment process - KEEPSAFE**

Patient restraint will only occur following the assessment process where the following factors must be considered;

- Known history of abuse/trauma
- Evaluation of prior restraint use
- Extra reasons for the patient's behavior
- Psychological, gender and cultural aspects of the patient
- Strategies and interventions considered
- Advance directive that the patient may have made concerning restraint
- Further risks associated with the intended restraint on the patient/family/environment
- Expected outcome for restraint use

In assessing whether restraint will be used, the patient, and/or where applicable their Enduring Power of Attorney, Welfare Guardian, parent/guardian if a child is under 18 years, or if such a person is not available, suitable persons interested in the patient's welfare should be informed and involved.

**Indications for unplanned immediate restraint use / process- HER**

Restraint may be initiated without prior consultation in instances when the patient's behavior changes unexpectedly where/when:

- H A patient makes a serious attempt or act of harm to self or another person.
- E A patient seriously compromised the facility's environment e.g. damaging property.
- R A patient's behavior indicated they are a significant risk to themselves or others.

In this situation phone 777 for a security response and identify your location.

**In these circumstances the following will be implemented;**

- Least restrictive/intrusive method of restraint will be implemented
- The use of restraint must be authorised by a health professional
- The continued use of restraint will be reviewed as soon as practical
- A senior nurse on duty will notify the Enduring Power of Attorney, Welfare Guardian, parent/guardian if a child is under 18 years, or if such a person if not available, suitable person interested in the patient's welfare as soon as possible when unplanned immediate restraint has been used.
- Following any unplanned immediate restraint use the patient must be assessed for physical/psychological injury. If any noted these must be documented in the Patient's Clinical record and the Patient Restraint Use Form. The patient must be seen and assessed by a medical professional. If a staff member sustains injury during the restraint episode appropriate medical treatment will be sought and relevant ACC documentation completed.

**NB. Never leave a patient in a prone position when restrained.**

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### Restraint Alternatives

Recognition and promotion of restraint alternatives are to be considered prior to restraint implementation.

Alternative options can include but are not limited to;

#### Environmental Changes

Improved lighting	Non slip mats at bedside
Clear furniture pathway	Lower bed height
Bedside mattress	Cushion positioning

#### Activities and Programmes

Consider ambulation opportunities  
Physical, occupational and recreational activities  
Family/whanau involvement

#### Toileting

Frequent assistance  
Ongoing evaluation

#### Seating

Deep seated chairs

#### Alarms

Call bell within reach  
At risk patients located near nurses station

#### Physiological

Review fluid intake  
Assess pain levels  
Review medications

## 12. Medication

The term chemical restraint is often used to imply that rather than using physical methods to restrain a consumer at risk of harm to their self or others, various medications are used to ensure compliance and to render the person incapable of resistance. Use of medications in this manner as a form of "chemical restraint" is not supported by the standards.

All medications should be prescribed and used for valid therapeutic indications. Appropriate health professional advice is important to ensure that the relevant intervention is appropriately used for therapeutic purposes only (RMSP NZS 8134.2).

Appropriate use of medication should not be referred to as "chemical restraint". The term "chemical restraint" refers to the inappropriate use of medication and is in breach of RMSP NZS 8134.2

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**13. Application of restraint**

The safety of all patients and staff involved in the restraint process must be maintained at all times.

Only RMAC approved restraints can be applied as listed on the RMAC approved restraint list.

The restraint process will be in accordance with the NZS8134.2:2008 Standard. Except in an unplanned emergency situation where immediate restraint is necessary for the safety of the patient or any other person, restraint will occur only after the assessment has been completed by the most appropriate health professional and all alternatives have been exhausted.

**14. Initiating and ending restraint**

The decision to initiate and end restraint must be made by the most appropriate health professional.

**15. Monitoring procedure**

To minimise the risk of harm to the patient during any period of restraint the patient's physical safety, comfort and treatment needs must be met at all times. This includes the provision of foods/fluids, toileting, meds and management of potential pressure areas for planned restraint episodes. The patient's right to dignity, privacy and self respect will be maintained during the restraint episode. During the period of restraint regular observations will be completed according to the consent form and care plan. Release from planned restraint in non mental health areas for mobilisation, toileting etc will occur at least two hourly.

**16. Support of patient, family/whanau and staff**

The impact and stress associated with restraint will be minimised by;

- The participation of the patient, or the patient's Enduring Power of Attorney, Welfare Guardian, parent/guardian if a child is under 18 years, or if such a person is not available, suitable persons interested in the patient's welfare in all restraint decisions where practicable.
- Ensuring timely communication
- Provision of support/advocacy to the patient
- Provision of staff training/support (including debriefing) as necessary

**17. Review and evaluation**

The RMAC will conduct annual organisation audit of restraint episodes and processes which evaluates;

- The extent of restraint use and any trends
- Adverse outcomes
- Compliance with this policy and procedure
- Whether the approved restraint was necessary, safe, of an appropriate duration, and appropriate in light of feedback from the patient and health professional involved in the restraint, and current accepted practice.

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- If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation
- Whether changes to policy, procedures, or guidelines are required.
- Whether there are additional competency or training needs of staff
- Progress made towards a restraint free environment.

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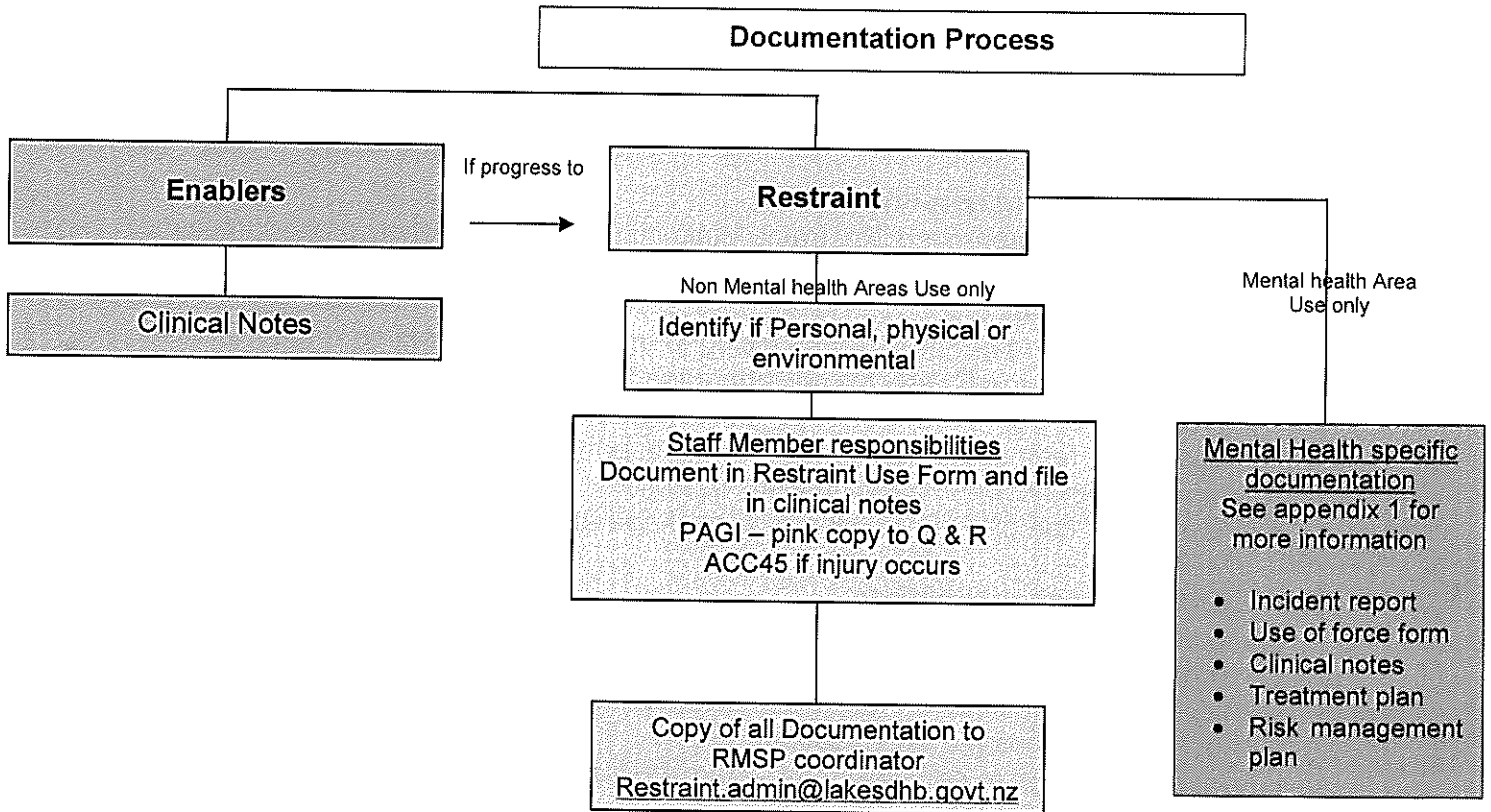
**Documentation must:**

Every episode of restraint will be documented as a PAGI and forwarded to the Quality & Risk Coordinator and RMSP coordinator.

Every episode of restraint must have the Restraint Use Form completed and associated process actioned as in Documentation Process Flow Chart below.

Documentation must be sufficient to enable a review of the restraint episode and include;

- The clinical rationale for the restraint
- Alternative interventions that were considered or attempted prior to using restraint
- Details of the advocacy/support offered, provided or facilitated
- Any injury to any person as a result of the use of restraint
- The effect/impact and the patient's response to the restraint
- Observations and monitoring of the patient during the restraint
- The outcome of the restraint.



The restraint register, records and clinical records will be utilised during the audits, with results discussed in the RMAC meetings and reported through the relevant clinical Governance Group

The RMAC will be responsible for monitoring implementation of recommendations.

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## 18. Responsibilities

The following are clinical activities and decisions which are undertaken by the health professional pre, during and post the restraint episode.

### **Clinical Staff responsibilities;**

Undertake the appropriate assessment of the situation

Assess patient ability to provide informed consent

In non mental health situations where there is imminent threat of physical harm/damage to the patient, staff or property phone 777, stating location and determine if police response is required.

Make the decision whether restraint is required

Monitor the health and wellbeing of the person if restraint is required.

Monitor the patient's need for continued restraint and ensure its use for the least amount of time possible

Make the decision to cease restraint.

Report the restraint episode via the required documentation (see documentation flowchart)

Document the restraint episode in the patient's clinical record including impact of restraint on the patient e.g. increased agitation or situation defused.

Complete RMSP learning package at required intervals.

### **Unit management responsibilities;**

Maintenance of approved Restraint Minimisation Safe Practice procedures and facilitation of education appropriate to individual clinical settings – approval is through the RMAC

All forms of restraint not currently included in the list of approved restraints must be presented to the RMAC for consideration for approval. Restraints not listed on the register of approved restraints must not be used. In the event of unplanned immediate restraint the police are responsible for this process. See Memorandum of Understanding with NZ Police.

Ensure staff complete RMSP learning package at required intervals.

### **Corporate responsibilities;**

Lakes District Health Board will maintain a committee (currently the RMAC) whose responsibilities will include;

The approval and review of all forms of restraint, types, education, policy and procedures across the organisation.

6 monthly audits in service areas where restraint has occurred and 12 monthly audits in all other areas.

Promotion of the intent of the NZRMSP standard to all Lakes DHB staff with patient contact.

Ensure ongoing opportunities for education are provided.

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**19. Cultural Recognition**

The holistic framework of Te Whare Tapu Wha is central to the recovery of Maori. The four dimensions are;  
Te taha hinengaro – mental wellbeing  
Te taha tinana – Physical wellbeing  
Te taha wairua – Spiritual wellbeing  
Te taha whanau – family/whanau wellbeing

Consultation will take place with family/whanau (where possible and appropriate) to ensure awareness of cultural values and beliefs.

Interpreter services will be arranged where necessary to ensure patient needs are recognized and endeavored to be met.

Patients will be assisted in accessing spiritual support where identified as important to the individual patient. If it becomes necessary to remove personal objects of significance e.g. Taonga, cultural symbols, to maintain patient safety this will be respectfully achieved where possible with family assistance.

**20. Training**

All clinical staff are to complete restraint minimisation and safe practice training (RMSP) within three months of commencing work at Lakes District Health Board. Staff will receive RMSP training at a frequency determined by RMAC in response to the 6 monthly audits where identified service areas have used restraint. Two yearly refresher options will be provided

**PLANNED EPISODES**

**21. Consent**

**PLANNED**

All intended restraint must be explained to the patient or the family/whanau, Welfare guardian or Enduring Power of Attorney by the appropriate health professional and approval gained to apply the restraint. A signed informed consent section on the Lakes District Health Board record form indicates approval.

**UNPLANNED**

Apart from the unplanned immediate situation, written or verbal consent must be obtained by the family/whanau, Welfare guardian or Enduring Power of Attorney as soon as practically possible following the emergency restraint procedure. See Informed Consent Policy EDMS 40045.

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**22. Legislation**

Health and Disability Services (Safety) Act 2001  
 Health and Disability Services NZS 8134:2008  
 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards NZS 8134.2:2008  
 Health and Disability Commissioner Act 1994  
 Code of Health and Disability Services Consumers' Rights  
 Health Information Privacy Code 1994  
 Human Rights Act 1993  
 New Zealand Bill of Rights 1990  
 Privacy Act 1993  
 Health and Safety in Employment Act 1992  
 Protection of Personal and Property Rights Act 1988

**23. Related Documents**

Informed Consent Procedure - EDMS 40045  
 Informed Consent Policy - EDMS 39082  
 Staff Safety Guideline - EDMS 39337  
 Risk Assessment - EDMS 39334  
 MOU between Lakes DHB and NZ Police  
 MOU between Lakes DHB and Prison Service

**24. References**

RMSP Standards NZS 8134.2:2008

**Prepared by:**

Cheryl Ingram-Clark  
 RMSP coordinator

**Authorised by:**

Gary Lees  
 Director of Nursing and Midwifery

**Endorsed by:**

Restraint Minimisation Approval Committee

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**Appendix 1.**

**TITLE: Mental Health & Addiction Services(MH&AS)  
Personal Restraint Procedure**

**1. Statement/Purpose**

- Lakes District Health Board strives to create a least restrictive, safe and appropriate environment. This allows us to uphold the dignity of the individual while providing excellence in care delivery.
- We also recognise that providing a safe environment and preventing injury is essential to obtaining desired outcomes and demonstrating respect for patients in our care.
- Restraint use is therefore limited to those circumstances where the patient is clearly identified as being at risk of injury to himself or to others and alternative safety measures have been evaluated and deemed inadequate.
- To ensure that restraint or enablers are an approved, skilled intervention by staff to prevent clients and patients from harming themselves or others.
- Restraint or enablers will be used in accordance with the Restraint Minimisation and Safe Practice Policy and Procedure developed by the Restraint Minimisation Approval Committee (RMAC) in Lakes District Health Board in accordance with the NZS8134.2:2008 standard

**2. Scope**

this procedure is to be followed by all Lakes Mental health and Addictions services staff members.

**Exclusions**

This Restraint procedure does not include the normal practice of locking doors and areas for security and safety reasons.

**3. Introduction**

Personal restraint should always be a planned process under the direction of a registered health professional.

Personal restraint is only applied by staff who have completed specific training in correct use of approved techniques as below:

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- All new staff **MUST** attend a four day Personal restraint training prior to being involved in any physical restraint procedure, unless they have attended prior training approved by CNM/CNS.
- This training will occur no later than three months following commencement of employment.
- All staff are to attend revalidation training every nine months
- If family/whānau members or visitors behaviour is threatening and presents a high level of danger to staff or public safety, the Lakes Security Policy (EDMS 495605) will apply.

#### 4. Indications for use

- Patients who are admitted for mental health care may have personal restraint applied by appropriately trained staff if the need arises.
- Consultation with the medical staff occurs regarding the provision of essential clinical treatment to an individual refusing treatment.
- Episodes of restraint are evaluated and information gained used to improve restraint practices.

#### 5. Important considerations

Situations of extreme caution – when the use would threaten to compromise the well being of the individual or others, consideration should be given to the comparative risks of using restraint or not

If after clinical assessment there is a suspicion that a person may be under the influence of alcohol and/or illicit substances, appropriate assistance should be sought and restraint used with caution, giving consideration to the clients physical condition.

Any decision to initiate restraint must be made by the most appropriate/designated health professional who shall consider the following:

- The clients physical and psychological health
- The clients gender and culture
- The degree of risk to the individual others and the environment
- Possible alternative interventions/strategies
- Experience of the individual and possible compromise to the future therapeutic environment
- Desired outcome and criteria for ending restraint
- Legal status and implication

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**6. Implementing**

Only staff with current competency will be involved  
 Only approved techniques are to be used  
 Dignity, privacy, safety and self respect for the client is paramount  
 Consideration is to be given to the clients cultural mores  
 At least one person of the clients gender is to be present, unless impossible, during the restraint process.

**7. Monitoring**

Monitoring of clients physical health and safety, and psychological wellbeing, shall be continuous by all members of the team, and considering any pre-existing physical conditions.

The restraint team leader maintains communication with the client and team through the restraint in order to:

- Ensure the client is informed of the actions and intervention of the restraint team
- To ensure any indication of pain by the client is responded to.
- Responding to any indication of distress during restraint.

**8. Ending**

Personal restraint must be discontinued as soon as possible with consideration for clinical indicators and safety.

The decision to end personal restraint is made by the restraint team leader in consultation with the restraint team, the client, and others involved.

Following discontinuation, the client is to be reintegrated into the appropriate environment and given the opportunity to discuss the event and impact.

Follow up to investigate any physical harm or treatments required by the client shall be conducted in accordance with policy and procedure.

**9. Documentation and review**

Following any episode the documentation will include:

- Incident report
- Use of force form
- Clinical notes
- Treatment plan
- Risk management plan

Lakes District Health Board: Restraint Minimisation Advisory Committee		Key Word(s): Restraint, Minimisation, Enabler, Safe Practice		Document number: 62131
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Evaluation and review includes debrief with the client and with the team as soon as practicable. This is to ascertain:

- Were there alternative strategies not attempted
- Opportunities for improvement of ongoing service delivery
- That standards are met.
- Feedback is implemented as part of a continuous quality improvement process

## 10. Related Documentation

- Use of Force S122B MHA
- Patient Admission to Discharge Planning Procedure (LDHB 39110)
- Falls Risk – Prevention and Management of Patient Falls (LDHB 105442)
- Informed Consent Policy (LDHB 39082)
- Informed Consent Procedure (LDHB 40045)
- Mental Health Service Comprehensive Assessment (LDHB 39228)
- Patient Accident / General Incident Management Procedure (LDHB 39539)
- Restraint (Personal) Procedure (LDHB 39333)
- Risk Assessment (LDHB 39334)
- Staff Safety Guideline (LDHB 39337)
- Health and Disability Commissioner Act 1994
- Health and Disability Code of Patient Rights 1996
- Health Information Privacy Code 1994
- Human Rights Act 1993
- Mental Health (Compulsory Assessment and Treatment) Act 1992 and amendments 1999
- New Zealand Bill of Rights 1990
- Privacy Act 1993

## 11. References

- Are We All Safe, Personal Restraining Course Handbook, Lakes DHB Mental Health Services
- Restraint Minimization and Safe Practice (health and disability sector standard)

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Processed by: Rachel Sharp

## Patient Restraint / Enabler Record Form

(All patients who require individual limb movement restrictions using equipment *with or without consent* must have assessment and monitoring recorded – other enablers are documented in clinical notes)

Documentation process to complete when initiating, during and after a restraint episode			
<b>DATE:</b> <b>WARD:</b>	<b>TIME:</b> <b>Initiating nurse:</b>	<b>During restraint event</b> <input type="checkbox"/> Complete monitoring documentation Page 4 – print additional pages if required  <b>Conclusion of restraint event</b> <input type="checkbox"/> Complete page 2 – discontinuation of restraint and page 3 evaluating the restraint. <input type="checkbox"/> Enter event into DATIX attach a copy of entire form to the submission / remember to include any additional monitoring pages if used.	
<b>RN initiating restraint</b> <input type="checkbox"/> Complete page 1 and page 2 of this restraint record form <input type="checkbox"/> Scan completed page 1 and page 2 to <a href="mailto:restraint.admin@lakesdhb.govt.nz">restraint.admin@lakesdhb.govt.nz</a> <input type="checkbox"/> Commence monitoring documentation as required – Page 4 of this form			
Initial Assessment			
Clinical justification leading to restraint / enabler use			
<b>Violent or Self Destructive behaviour leading to unplanned immediate restraint use (please detail)</b> <input type="checkbox"/> Imminent risk of harm to self <input type="checkbox"/> Imminent risk of harm to others <input type="checkbox"/> Imminent risk of damage to therapeutic environment  _____ _____		<input type="checkbox"/> Inability to respond to direct requests or follow instructions <input type="checkbox"/> Pulling at lines / tubes <input type="checkbox"/> Removal of therapeutic interventions eg oxygen <input type="checkbox"/> Removal of dressing <input type="checkbox"/> Other (please detail)  _____ _____	
De-escalation / Alternatives attempted prior to restraint initiation			
<input type="checkbox"/> Yes <input type="checkbox"/> Environmental changes <input type="checkbox"/> Family or whanau or carer support/involvement <input type="checkbox"/> Distraction/activity <input type="checkbox"/> Pain assessment/management <input type="checkbox"/> Re-orientation (time/place/person)		<input type="checkbox"/> Medication review <input type="checkbox"/> Enhanced observation <input type="checkbox"/> Patient relocation <input type="checkbox"/> Nutrition/hydration needs <input type="checkbox"/> Physical comfort issues addressed e.g. toileting/positioning	
<input type="checkbox"/> No Please state why not _____ _____			
<b>Who is involved in the decision making?</b>		<input type="checkbox"/> Nurse manager <input type="checkbox"/> Consultant <input type="checkbox"/> Duty / Service manager <input type="checkbox"/> Patient <input type="checkbox"/> Registrar / HO <input type="checkbox"/> Patient's family <input type="checkbox"/> Patients nurse <input type="checkbox"/> EPOA / Advocate <input type="checkbox"/> Restraint co-ordinator <input type="checkbox"/> Other (please state)	
<b>In deciding to use restraint, please answer the following questions:</b> Is there any known history of abuse/trauma? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Do you have any knowledge of prior restraint use? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Are there any known reasons for the patient's behaviour? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>If Yes what are the reasons :</b>			
<input type="checkbox"/> Type of restraint required <input type="checkbox"/> Circle appropriate OR <input type="checkbox"/> Limb restrictions with consent that require additional monitoring.	<b>Personal</b> <i>Where a service provider uses their own body to intentionally limit the movement of a consumer</i>	<b>Physical</b> <i>Where a service provider uses equipment, devices or furniture that limits the consumers normal freedom of movement</i>	<b>Environmental</b> <i>Where a service provider intentionally restricts a consumers normal access to their environment or reduced level of social contact.</i>
<b>Restraint / Enabler used:</b> _____			
<b>Desired outcome of restraint usage?</b> Please describe:		<input type="checkbox"/> Patient is more calm and more compliant <input type="checkbox"/> Improvement in status <input type="checkbox"/> Clinical procedure completed <input type="checkbox"/> Change in environment – i.e. transferred to safe care unit	

*Patient Label*  
PLEASE ATTACH PATIENT LABEL HERE

Further considerations:			
	YES	NO	DATE AND TIME OF REFERRAL
▪ Hunga Manaaki / Te Oranga referral required?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Social Worker referral required?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ A-D cultural assessment used?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Interpreter required?	<input type="checkbox"/>	<input type="checkbox"/>	
	YES	NO	DESCRIBE
▪ Personal objects to be removed?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Objects given to family or whanau or carer?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Full explanation given to patient and family or whanau or carer with regard to need for restraint:	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Desired outcome communicated to patient/family or whanau or carer?	<input type="checkbox"/>	<input type="checkbox"/>	

Discontinuation of event	
Date the restraint ended:	Time the restraint ended:
Name of Nurse / Doctor discontinuing restraint :	
<b>Patient debrief:</b> <ul style="list-style-type: none"> <li>▪ Cultural values and beliefs</li> <li>▪ Return of belongings</li> <li>▪ Patient allowed time to discuss restraint impact with staff</li> </ul>	Describe patient's debrief:
Has the patient's family been advised of the restraint removal or episode	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was any review or modification of the patient's care plan required?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what? _____	
Was there any adverse physical/psychological effect on the patient?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what? _____	
Was a medical assessment obtained?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of medical professional _____	
<p>The NZ Standard requires that support is given post restraint episodes. Has any support been provided to:</p> <p>Patient Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>      Family/whanau Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>      Staff Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>If No or N/A, please explain</p>	
<p>Were any support services involved:</p> <p>Hunga Manaaki <input type="checkbox"/>      Te Oranga <input type="checkbox"/>      Chaplain <input type="checkbox"/>      Other (please state) <input type="checkbox"/>      No <input type="checkbox"/></p>	

Documentation / DATIX entry
<p>Ensure Pages 1-4 are completed – SCAN completed document</p> <ol style="list-style-type: none"> <li>1. Send SCANNED document to <a href="mailto:restraint.admin@lakesdhb.govt.nz">restraint.admin@lakesdhb.govt.nz</a></li> <li>2. Entry in DATIX – Incident affecting patient - Type Tier 1 – behaviour Type Tier 2 – patient restraint processes</li> <li>3. ACC45 must be completed if injury occurred and uploaded to DATIX</li> <li>4. Original documents remain in the patient notes</li> </ol> <p><b>DATIX INCIDENT NUMBER :</b></p>

*Patient Label*

PLEASE ATTACH PATIENT LABEL HERE

**Evaluating the restraint (involve patient / family / whanau where possible)**

	YES	NO	IMPROVEMENTS TO BE MADE
▪ Was patient, family/whanau/carer involvement been sought for evaluation of the restraint?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the initial indication for use of restraint appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was de-escalation or alternatives used appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the type of restraint used the least restrictive/intrusive possible to achieve the desired outcome?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the type of restraint used approved for use by LDHB?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the desired outcome achieved?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the duration of restraint appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the level of monitoring appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Were the patient's individual needs/beliefs considered?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Were cultural needs identified and met?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Has the impact on the patient been assessed?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Has the impact on staff involved been assessed?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the communication effective from all staff?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was adequate advocacy and support provided?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was the patient's right to dignity maintained?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Was there any injury to the patient as a result of restraint episode?	<input type="checkbox"/>	<input type="checkbox"/>	
▪ Any further comment			



# Restraint / Enabler monitoring

(Once restraint is discontinued please complete the discontinuation section on pages 2 and 3)

## Patient Label

PLEASE ATTACH PATIENT LABEL HERE

Monitoring to occur at:  
(please circle)      2 hourly   4 hourly   6 hourly   8 hourly   OR   Please state frequency and reason:

Date of assessment																				
Time of assessment																				
CNM / RN coordinator initials																				
RN initials																				
Reassessment of need to continue with restraint completed																				
Vital signs checked and noted in clinical notes																				
Repositioning including limb release if limb is restricted?																				
Skin integrity and circulation check completed																				
Toileting provision met?																				
Hydration/Nutrition needs met?																				
Cultural support offered?																				
COMMENTS																				
<b>Complete for limb restraint only</b>																				
Service manager/Duty manager / restraint coordinator initials – for any limb restraint. This must be completed at least every 8 hours. See policy for further details.															Date/ Time		Initial			